Clinical Community Linkages

This discussion will cover clinical community linkages in general, with a more detailed look at a case study with Gerald Family Care, PC.

Agency for Healthcare Research and Quality's Definition

Clinical community linkages help to connect health care providers, community organizations, and public health agencies so they can improve patients' access to preventive and chronic care services.

http://www.ahrq.gov

AHRQ's GOALS

The goals of clinical-community linkages include:

- Coordinating health care delivery, public health, and community-based activities to promote healthy behavior.
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services.
- Promoting patient, family, and community involvement in strategic planning and improvement activities.

http://www.ahrq.gov

Gerald Family Care PC

- Gerald Family Care, PC is a primary care service organization, specializing in Family Practice and related health services. We provide primary, preventive and managed care services with the highest levels of professionalism, compassion, and caring to families and individuals in need of health care. GFC has been serving the DC metro area since 1974, making 2014 its 40th year of service.

Our Locations

- 3 locations - Two in Prince Georges County and One the District of Columbia

Providers

- GFC currently has 4 physicians and 4 physician assistants. We are a PCMH Level 3 recognized practice and we have been electronic for 4 years.

GFC community linkages

- We are very active in our communities and participate with a number of initiatives that help our patients to have better health outcomes. We have a strong and productive relationship with the Prince Georges County Health Department and participate in many initiatives and projects.

Our Work with the Prince George's County Million Hearts Project (PGCMHP)

- GFC was assigned a Clinical Health Worker (CHW) who was responsible for conducting outreach to link patients to established medical homes, assist them in navigating the healthcare system, and refer them to social and other supportive services as needed. Our CHW worked with patients of our practice who met the criteria for the Maryland Million Hearts Initiative, specifically:
- uninsured or under-insured
- undocumented and/or homeless
- chronic disease (2 years or more) with the following measurements: hypertension (Blood Pressure > 140/90), hypercholesterolemia (Cholesterol > 240), and diabetes (HgA1C > 7)
- hospital re-admission or ER visit within 30 days for complications related to hypertension, hypercholesterolemia, and/or diabetes

Integration of CHW into GFCs operation:

- Worked with us in the office 8-10 hours per week average
- Joined our staff for morning huddles
- Worked with the Care Coordinator to review patients diagnosed with hypercholesterolemia, hyperlipidemia, diabetes controlled & uncontrolled, and coronary heart disease
- CHW with assistance of our providers would visit with patients during scheduled appointments to introduce program, schedule follow-up appointment to connect with patients at next visit.
- From a registry report of patient with no pending appointments she would make follow-up calls to schedule patients for appointments.

Integration of CHW into GFCs operation:

- CHW assisted with providing patients with 1) home blood pressure monitors and blood pressure log books to record reading and bring to office visits 2) glucometers and blood sugar log books to record reading and bring to office visits, 3) pedometers with suggested goals, 4) provide exercise opportunities, 5) Arrange transportation for appointments or other resource activities - as appropriate for their specific needs.
- CHW followed up with patients in 2-3 weeks to ensure that they received their medical equipment and invite them in for additional training if there were any problems or difficulties using equipment.
- Home visits if: demonstrated learning difficulty to teach operation of equipment, additional family resources available and warranted, deliver supplies when difficult for patient to receive, missed appointment and unable to reach.

Integration of CHW into GFCs operation:

- CHW communicated with patients via email, mailing, office drop in, office visit to provide educational and resource material.
- The CHW would also communicate with Prince George's County residents who we are alerted of having hospital activity (ER and inpatient) and calls to arrange follow-up visit or get information about activity.
- Contacted patients seen with diabetes and hypertension diagnoses (from a designated time period) to invite them to education classes given by county or hospitals
  - Provides information to patients concerning class content
  - Provides flyers for take-away by patients
  - Assists with logistics for patients for the class

Case Study

- A 39 year old female patient diagnosed with diabetes greater than 3 years ago. Her social situation is unstable and she does not have a stable address although she is not “homeless”. This patient was recommended treatment with insulin four times a day.

- However, in 2-2013 was found by the Primary Care Physician to be using insulin “as needed” (when symptomatic) rather than “as ordered” due to reported history of multiple scars after use with insulin.

- The PCP referred the patient to the care management who developed a care plan and started having patient come in every day to administer\review\teach insulin, this progressed to every two days for a short period, then on to every 3-4 days for a period.

Case Study

- During this time the patient was referred to Prince Georges County Health Department Community Health Worker who is in our practice twice a week. The CHW contacted patient about attending a diabetic education class sponsored by the health department. She called patient and invited the patient to the diabetes class. Patient attended diabetes class, the class was held for approximately for 90 minutes and this patient was so engaged she stayed behind with questions.

- The CHW helped reinforce the need for the patient to understand and to manage her disease and linked her to a community resource.

- Now the Care Management team feels that the patient has mastered self administration of insulin, can verbalize signs and symptoms of hyper & hypoglycemia, can discuss her goals for her blood sugar-weight-blood pressure

  amount of physical activity, can verbalize her medication schedule.

Case Study

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- Improvements patient currently sees an endocrinologist for regularly scheduled visits. She has seen an ophthalmologist and he Hemoglobin A1C has dropped from 15% to 11.4%.